MYCHART PROXY ACCESS FORM: ADULT

To sign up for MyChart access to the health information for an adult to whom you provide care (such as a family member), please complete this form in its entirety. This proxy-access form needs to be completed by both the proxy (the "grantee") and by the patient (the "grantor").

By completing this form, the MyChart account holder (the proxy/grantee) will have access to the MyChart records of the patient/grantor. However, before a MyChart proxy can be established, the proxy/grantee needs to complete the MyChart request form to set up access to his/her own MyChart account.

After this form has been filled out, please return it to Confluence Health (the mailing address and fax number are listed at the end of the form). An activation code will be mailed to you, which you must use to complete the registration process online at **https://mychart.confluencehealth.org/MyChart/**

1) Adult Proxy/Grantee

Name *(last, first, middle initial)*____ **Date of Birth** _________________________

Address____

City _______________________________________ **State** _________ **Zip** ___________ **Phone** ______________________

Email ____________________________________**Primary Provider** ____

2) Adult Patient/Grantor: If you are an adult who manages the medical care for another adult and you would like to access his/her MyChart record, please provide the adult patient's information. In addition, the adult patient/grantor must sign the "Release of Information" section below to provide authorization for the release of his/her medical information to you, the proxy/grantee, through MyChart.

Please provide the following information on the adult patient/grantor:
NOTE: If more than one adult proxy access is required, please complete an additional form(s)

Name *(last, first, middle initial)*____ **Date of Birth** _________________________

Address____

City _______________________________________ **State** _________ **Zip** ___________ **Phone** ______________________

Email ____________________________________**Primary Provider** ____

3) Release of Information from Adult Patient/Grantor to Adult Proxy/Grantee
This is an authorization that will permit Confluence Health to release your medical information to your designated adult proxy/grantee. ***Please ready carefully.*** This section should be completed by the patient/grantor who is authorizing an adult proxy/grantee to access the medical information in the patient/grantor's MyChart record.

I, the adult patient/grantor, am requesting that ____ ***(insert name of proxy/grantee from section 1)*** receive access to my health information that is available in my Confluence Health MyChart record. This person is my designated MyChart proxy. I authorize Confluence Health to release the health information contained in my MyChart record to my MyChart proxy. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all Confluence Health facilities. I authorize release of any information contained in my MyChart medical record held by Confluence Health to my designated proxy.

I authorize release of this information only through my MyChart record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms. I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy, and the disclosed information may not be covered by federal privacy protections.

Participation in MyChart and designating a MyChart proxy is completely voluntary. I understand that I am not required to designate a MyChart proxy and I am not required to provide this authorization. I also understand that Confluence Health does not base any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, Confluence Health is not permitted to provide access to my MyChart record to my designated proxy.

I may revoke this authorization at any time by providing a written request to Confluence Health, Medical Records Department. I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will be terminated. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

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Release of Information continued:

I acknowledge that I have read and understand this MyChart sign-up form. I agree to its terms and choose to designate the person named above (the proxy/grantee) as my MyChart proxy, thereby allowing him/her to access my MyChart medical record.

Adult Patient / Grantor Signature *(Required)*	**Relationship to Proxy** *(Required)*	**Date** *(Required)*
Proxy Signature *(Required)*	**Relationship to Patient** *(Required)*	**Date** *(Required)*

Fax completed form to **(509) 665-3494** or mail to:
Confluence Health
Patient Services Department
PO Box 489, Wenatchee, WA 98807

For Official Use:
I have received a copy of the required guardianship and or Durable power of attorney for healthcare verification.

Date_____________ Initials_______

Please send all Proxy requests to Medical Records to be processed.